§133.301. Retrospective Review of Medical Bills.

(a) The insurance carrier shall retrospectively review all complete medical bills and pay for or deny payment for medical benefits in accordance with the Act, rules, and the appropriate Division fee and treatment guidelines. The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Benefits - Guidelines for Medical Services, Charges, and Payments). The retrospective review may include examination for:

(1) compliance with the fee guidelines established by the Division;

(2) compliance with the treatment guidelines established by the Division;

(3) duplicate billing;

(4) upcoding and/or unbundling;

(5) billing for treatment(s) and/or service(s) unrelated to the compensable injury;

(6) billing for services not documented or substantiated, when documentation is required in accordance with Division fee guidelines or rules in effect for the dates of service;

(7) accuracy of coding in relation to the medical record and reports;

(8) correct calculations; and/or

(9) provision of unnecessary and/or unreasonable treatment(s) and/or service(s).

(b) Neither the insurance carrier nor the carrier's agent shall change a billing code on a medical bill or reimburse treatment(s) and/or service(s) at another billing code's value unless the insurance carrier contacts the sender of the bill and the sender agrees to the change.

(1) If the sender of the medical bill agrees to a specific change in a billing code, the insurance carrier shall make the change on the medical bill and use that code in the electronic transmission of the medical bill data to the Division under §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Commission).

(2) If the insurance carrier changes a billing code with the agreement of the sender, the insurance carrier shall maintain documentation regarding the manner in which the agreement was reached, the name and telephone number of the person who agreed to the change, and the date the agreement was reached.

(c) An insurance carrier's request for additional documentation shall:

(1) clearly indicate the specific documentation the insurance carrier is requesting;

(2) indicate the specific reason for which the insurance carrier is requesting the information;

(3) include a copy of the bill for which the insurance carrier is requesting the additional documentation;

(4) be made by, facsimile, mutually agreed upon electronic transmission, or telephone; if by telephone, the insurance carrier shall document the name and telephone number of the person who supplied the information; and

(5) be made not later than the 45th day after receipt of the medical bill.

(d) The insurance carrier shall maintain a copy of the request for additional documentation or be able to electronically reproduce it and shall maintain documentation of the date the insurance carrier sent the request to the health care provider.

(e) A health care provider shall submit to the insurance carrier, no later than the 15th day after receipt of a request for additional documentation in accordance with this section, any additional documentation, records, or information related to the treatment(s) and/or service(s) rendered, or the charges billed. If the insurance carrier requests documentation that the health care provider does not have, the health care provider shall send the insurance carrier a notice to that effect within 15 days after the date the health care provider received the request. The health care provider shall send documentation and notice provided by this subsection to the insurance carrier by facsimile or mutually agreed upon electronic transmission unless the requested documentation cannot be sent by those media, in which case the health care provider shall send the documentation by mail or personal delivery.

(f) A health care provider's failure to timely provide an insurance carrier with additional documentation submitted in accordance with this section does not extend the amount of time the insurance carrier has to make payment or deny payment on a bill in accordance with §133.304 of this title (relating to Medical Payments and Denials).

(g) This rule shall apply to all dates of service on or after September 1, 2005.

§133.302. Preparation for an Onsite Audit.

(a) An insurance carrier may perform an onsite audit of a health care provider that has billed the insurance carrier, if the insurance carrier provides a notice of intent to perform an onsite audit in accordance with subsections (c) and (d) of this section.

(b) An onsite audit may focus on workers' compensation claims in which the insurance carrier:

(1) is currently conducting retrospective review of a medical bill the health care provider submitted for payment; or.

(2) previously took final action in accordance with §133.304 of this title (relating to Medical Payments and Denials.

(c) If an insurance carrier decides to conduct an onsite audit, the insurance carrier shall:

(1) provide notice required by subsection (a) of this section not later than the 45th day after the date the insurance carrier received the complete medical bill; and

(2) complete the audit not later than the 160th day after the date of receipt by the insurance carrier of the health care provider's medical bill and pay, reduce, or deny in accordance with §133.304 of this title.

(d) The notice of intent to perform an onsite audit shall include the following information for each workers' compensation claim that is the subject of the audit:

(1) the employee's full name, address, and social security number;

(2) date of injury;

(3) the date(s) of service for which the audit is being performed;

(4) the insurance carrier's name and address;

(5) the name and telephone number of the person to contact with questions about the audit;

(6) the name of the individual who will represent the insurance carrier and who will perform the onsite audit; and

(7) two dates that the insurance carrier proposes to conduct the onsite audit. These dates shall be no later than 14 days after the date the insurance carrier notifies the health care provider of its intent to perform an onsite audit.

(e) If the health care provider is unable to schedule an onsite audit on the dates proposed by the insurance carrier, the health care provider shall notify the insurance carrier in writing, within seven days of

receipt of the insurance carrier's notification of intent to perform an audit, of an alternate onsite audit date and time.

(f) This rule shall apply to all audits of medical bills with dates of services on or after September 1, 2005.

§133.304. Medical Payments and Denials.

(a) Except as provided in subsection (d) of this section, an insurance carrier shall take final action on a medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill.

(b) Final action on a medical bill includes one or more of the following:

(1) sending payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §133.1(8) of this title (relating to Definitions for Chapter 133 - Benefits--Medical Benefits); or

(2) denying a charge on the medical bill.

(c) At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Division, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Division's, instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. The insurance carrier shall maintain documentation of the date it sent the explanation of benefits, and shall either maintain a copy of the explanation of benefits or be able to electronically reproduce it. The explanation of benefits may be printed on the insurance carrier's letterhead but must include all language required by the Division.

(d) If the insurance carrier performs an audit the insurance carrier shall:

(1) no later than the 45th day after the date of receipt of the medical bill, pay no less than 85% of:

(A) the maximum allowable reimbursement amounts provided by the Division fee guidelines in effect for the dates of service being audited;

(B) the contracted amount; or

(C) the amount billed for treatment(s) and/or service(s) without an established maximum allowable reimbursement; and

(2) not later than the 160th day after the date of receipt of the medical bill, make a final determination and pay, reduce, or deny the audited medical bill.

(e) The insurance carrier shall send a copy of the explanation of benefits to the injured employee at the same time it is sent to the sender of the bill if the insurance carrier has reduced or denied payment for a charge on the bill because the insurance carrier believes that treatment(s) and/or service(s) were:

(1) unreasonable and/or unnecessary;

(2) provided by a health care provider other than

(A) the treating doctor selected in accordance with §408.022 of the Texas Labor Code,

(B) a health care provider that the treating doctor has chosen as a consulting or referral provider,

(C) a doctor performing a required medical examination in accordance with §126.5 of this title (relating to Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Order for Required Medical Examination), or

(D) a doctor performing a designated doctor examination in accordance with §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings; or

(3) unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(f) If an insurance carrier denies or reduces payment for a medical bill based on a peer review, the health care provider who conducts the peer review shall:

(1) be a licensed health care provider, as defined in §401.011 of the Texas Labor Code, of the same or similar specialty as the prescribing or performing health care provider;

(2) be licensed to prescribe or perform the category of treatment(s) and/or service(s) under review; and

(3) if a doctor, must not have been removed from the Division's approved doctor list.

(g) When an insurance carrier reduces or denies payment for treatment(s) and/or service(s) on the recommendation of a peer review as described in subsection (f) of this section, the insurance carrier shall provide a copy of the peer reviewer's report to the sender of the bill, with the explanation of benefits. The report shall include:

(1) the peer reviewer's professional discipline,

(2) the peer reviewer's specialty information, and

(3) the name and professional license number of the peer reviewer.

(h) When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Division has not established a maximum allowable reimbursement, the insurance carrier shall:

(1) develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

(2) explain and document the method it used to calculate the rate of pay, and apply this method consistently;

(3) reference its method in the claim file; and

(4) explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement.

(i) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by §409.021 of the Texas Labor Code, §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for treatment(s) and/or service(s) based solely on the carrier's belief that:

(1) the injury is not compensable;

(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the treatment(s) and/or service(s) was provided was not related to the compensable injury.

(j) If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit the request for reconsideration by facsimile or mutually agreed upon electronic transmission unless the request cannot be sent by those media, in which case the sender shall send the request by mail or personal delivery; the request shall include:

(1) a copy of the complete medical bill that the health care provider is requesting the insurance carrier to reconsider,

(A) clearly marked with the statement "REQUEST FOR RECONSIDERATION," and

(B) with the identical codes and charges that are on the original medical bill;

(2) a copy of the explanation of benefits; and

(3) a claim-specific substantive explanation that enables the insurance carrier to understand the sender's position. This explanation shall rebut the insurance carrier's reason for its action as indicated on the explanation of benefits. A generic statement that simply states a conclusion such as "insurance carrier improperly reduced the bill" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

(k) An insurance carrier shall treat a request for reconsideration as an incomplete medical bill under §133.300 of this title (relating to Insurance Carrier Receipt of Medical Bills from Health Care Providers) if the request is not submitted in accordance with subsection (j) of this section. Within 21

days of receiving the request for reconsideration, the insurance carrier shall take final action on the medical bill as described in subsection (b) of this section, provided the request for reconsideration meets the requirements of subsection (j) of this section.

(l) The sender of a medical bill may request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution - General) if the sender of a medical bill has requested reconsideration in accordance with this section and:

(1) after reconsideration, the sender is still dissatisfied with the insurance carrier's action on the medical bill; or
(2) the sender has not received the insurance carrier's response to the request for reconsideration by the 28th day after the date the request for reconsideration was sent to the insurance carrier.

(m) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits explaining its actions except as provided in subsection (j) of this section and §133.305 of this title (relating to Medical Dispute Resolution - General).

(n) A health care provider who receives a request for the refund of payment for medical treatment(s) and/or service(s) shall, by the 45th day after receipt of the request:

(1) pay the request; or

(2) submit to the insurance carrier a specific explanation regarding the reason the health care provider has failed to make the payment requested. A generic statement that simply states a conclusion such as "insurance carrier cited the wrong ground rule" or other similar phrases with no further description of the factual basis for the health care provider's position does not satisfy the requirements of this section. The health care provider shall send the explanation by facsimile or mutually agreed upon electronic transmission unless the explanation cannot be sent by those media, in which case the health care provider shall send the explanation by mail or personal delivery.

(o) An insurance carrier may request medical dispute resolution in accordance with §133.305 of this title if the insurance carrier did not earlier make full payment on the medical bill in accordance with §413.031 of the Texas Labor Code, the insurance carrier has requested a refund under this section, and the health care provider:

(1) failed to make payment by the 45th day after the date the insurance carrier sent the request for refund; or

(2) failed to pay the amount of refund requested, including interest, if applicable.

(p) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.803 of this title (relating to Calculating Interest for Late Payment on Medical

Bills and Refunds). Interest shall be paid from the 60th day after the date of receipt of the complete medical bill to the date of payment, without order of the Division.

(q) All refunds requested by the insurance carrier and paid by a health care provider on or after the 60th day after the date the health care provider received the request for the refund shall include interest calculated in accordance with §134.803 of this title. Interest shall be paid from the 60th day after the date of receipt of the request for refund to the date of payment.

(r) This rule shall apply to all dates of service on or after September 1, 2005.

§134.801. Submitting Medical Bills for Payment.

(a) The health care provider shall submit all medical bills to the insurance carrier unless the injured employee's employer has indicated a willingness to pay the medical bill(s), and the health care provider elects to bill the employer. If the health care provider bills the employer the health care provider shall submit a copy of the bill to the carrier and shall state the following in bold type: "THIS IS ONLY AN INFORMATION COPY, IT IS NOT A REQUEST FOR PAYMENT."

(b) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

(1) prompt payment, as provided by §408.027 of the Texas Labor Code;

(2) interest for delayed payment as provided by §413.019 of the Texas LaborCode; and

(3) Division-provided medical dispute resolution as provided by §413.031 of the Texas Labor Code.

(c) A health care provider shall not submit a medical bill later than:

(1) the first day of the eleventh month after the date the services are provided, for services provided on or before August 31, 2005; or

(2) the 95th day after the date the services are provided, for services provided on or after September 1, 2005.

(d) If the injured employee, the employee's representative, or the Division requests an information copy of the medical bill, the health care provider shall send, at no cost, a copy of the medical bill indicating the identical codes and charges from the original medical bill. Information copies shall state the following in bold type: "THIS IS ONLY AN INFORMATION COPY, IT IS NOT A REQUEST FOR PAYMENT."

(e) The health care provider that provided the treatment(s) and/or service(s) shall submit its own bill, unless:

(1) The health care provider employs a billing service to perform the solely administrative function of submitting bills for the health care provider,

(2) The health care provider is providing treatment(s) and/or service(s) as part of an interdisciplinary program, in accordance with the Division fee guidelines in effect for the dates of service,

(3) the health care provider is submitting a bill in accordance with the pathology ground rules of Division fee guidelines in effect for the dates of service, or

(4) the treatment(s) and/or service(s) was provided by a unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill.

(f) A health care provider or other entity, except as described in subsections (e) and (h) of this section, may not submit a bill for treatment(s) and/or service(s) the health care provider did not provide.

(g) Any entity, including a health care provider, that submits a bill for a health care provider shall:

(1) submit the bill for an amount that does not exceed the health care provider's usual and customary charge for the treatment(s) and/or service(s) provided in accordance with §413.011 of the Texas Labor Code,

(2) submit the bill in the name and license number of the licensed health care provider that provided the treatment(s) and/or service(s) or that provided direct supervision of an unlicensed individual that provided the treatment(s) and/or service(s), and

(3) remit to the health care provider that provided the treatment(s) and/or service(s) the full amount that the insurance carrier reimburses for the treatment(s) and/or service(s).

(h) A health care provider shall not submit a medical bill to an injured employee for all or part of the charge for any treatment(s) and/or service(s), except as an information copy, or in accordance with §413.042 of the Texas Labor Code. A health care provider shall be deemed to be pursuing a private claim against an injured employee if the health care provider sends a medical bill or account statement to the employee that:

(1) does not clearly state that it is an information copy by including the following in bold type: "THIS IS ONLY AN INFORMATION COPY, IT IS NOT A REQUEST FOR PAYMENT"; and/or

(2) includes a statement that requests payment by asking for remittance of an amount, or that includes something similar to "amount due".

(i) An employer, other than a self-insured employer, is not liable for any part of the cost of medical benefits provided to an injured employee, even if a claim is finally adjudicated non-compensable, or the insurance carrier has denied, reduced, or disputed a medical bill. A health care provider shall not submit a medical bill to an employer for charges an insurance carrier has reduced, denied, or disputed.